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Implementation of midwifery continuity of care models for Indigenous women in Australia: perspectives and reflections for the United Kingdom

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None declared

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Not applicable

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ABSTRACT

Maternity models that provide midwifery continuity of care have been established to increase access to appropriate services for Indigenous Australian women. Understanding the development and implementation of continuity models for Indigenous women in Australia provides useful insights for the development and implementation of similar models in other contexts such as those for vulnerable and socially disadvantaged women living in the United Kingdom. To ensure better health outcomes for mothers and babies, it is crucial to promote culturally competent and safe public health models in which midwives work collaboratively with the multidisciplinary team.

SHORT COMMUNICATION / COMMENTARY

Disparities in health outcomes between Aboriginal and Torres Strait Islander peoples (hereafter referred to as Indigenous Australians) and non-Indigenous Australians are well known. The health status of Indigenous Australians is universally described within a deficit model i.e. life expectancy is 10–11 years less than their Australian counterparts, and they more likely experience chronic and communicable diseases, cancer, poor eye and dental health, social and emotional distress, and family violence[1]. Compared with non-Indigenous women, pregnant Indigenous women are more likely to die during childbirth, smoke during pregnancy and have more low birthweight babies and preterm births[2]. This health profile is very representative of intergenerational social economic disadvantage experienced by Indigenous people worldwide. Contributing factors are complex and range from the enduring effects of colonialism, social exclusion, systemic institutional racism, genetic predisposition and lifestyle issues[1]. For decades, Indigenous women in many countries including Australia have been championing culturally safe health services that promote health and wellbeing and includes a suite of services that improve pregnancy and birthing outcomes; prevention, early detection and treatment to address risk factors, reduce the burden of disease and increase survival rates[2]. To guarantee better health outcomes, public health strategies need to include knowledge and awareness of the Indigenous history, experience, culture and rights.

There have been a number of reports and strategies in Australia (i.e. Royal Commission into Aboriginal Deaths in Custody 1991 and the National Aboriginal Health Strategy 1989) as

well as national campaigns that have aimed to close the health and life expectancy gap between Indigenous and non-Indigenous Australians. One national initiative has been the 'Close the Gap' Campaign[3] which has intended to reduce neonatal and child mortality and to improve access to culturally appropriate health care. The Australian National Maternity Services Plan[4] was also used to highlight the importance of promoting access to models of care that provide continuity of care to improve health outcomes for Indigenous mothers and babies[5]. Several maternity models that provide midwifery continuity of care have since been established to increase access to appropriate maternity services for Indigenous women in Australia[6]. Some examples include the *Malabar Midwifery Community Service* in South Eastern Sydney[7]; The *Murri Antenatal Clinic* in South Brisbane which informed the *Birthing in Our Community* inter-agency life-course approach programme[8]; the Baggarrook Yurrongi (Woman's Journey) project in Melbourne and three more Victorian health services[9]; and the Midwifery Group Practice at the Alice Springs Hospital in the Northern Territory (NT)[10].

This commentary paper is the result of a study tour organised to understand the development and implementation of continuity of care models for Indigenous women in Australia and reflect on observations and lessons that could be useful for the development and implementation of continuity models for women living socially complex lives in the United Kingdom (UK). Meeting with Australian colleagues has been crucial to understand the complex redesign of maternity services and the implementation and sustainability of continuity of care models for Indigenous women who are living in the cities of Sydney, Melbourne and Brisbane, and the remote town of Alice Springs in the centre of the country. The study tour provided important insights into the diversity of service models in different geographic areas and the challenges faced by women accessing services and health services providing services. Collectively the sites shared similarities and differences. Each site was unique and there are numerous lessons to learn. Lessons learnt suggest that four implementation strategies were crucial: (1) establishing cohesive partnerships and collaborations to enhance funding, (2) having a shared vision and good leadership, (3) communicating clearly and engaging regularly with stakeholders (3) and promoting culturally and clinically competent public health models in which midwives work collaboratively with the multidisciplinary team including Indigenous health workers or health education officers, public health officers, obstetricians, general practitioners, psychologists, mental health nurses and support workers, paediatricians, and family and child nurses to facilitate a smooth transition to community and primary health services.

While these observations and lessons are from Australia and are highly contextualised (particularly the NT), there may be aspects that we can apply in other contexts, like the UK. Indigenous women, babies and families in Australia as well as many women, babies and families living socially complex lives in the UK often have a common experience of social and economic disadvantage, which results in poor health outcomes. Similarly, to some Indigenous women, socially disadvantaged women in the UK (e.g. those living in poverty; migrants, refugees and non-English speakers; domestic violence, substance abuse; young motherhood)[11] are more likely to have poorer birth outcomes, including more preterm births, stillbirths and both maternal and neonatal deaths. They also have more negative experiences of care than any other group of women and struggle to access and engage with maternity services[12,13]. Although the reasons for this are not fully understood, there are similar contributing factors: inequality of access to services, language barriers, fear of surveillance or disclosure to border agencies, unfamiliarity with processes, discrimination, or maternity care having less priority for women dealing with other more important issues such as poverty and gender violence.

In the UK, there is maternal policy focusing on increasing continuity of care models[14] and prioritizing the reduction of poor outcomes experienced by socially disadvantaged populations and women living socially complex lives[12,13]. This is a far cry from the reality of what the current fragmented maternity system provides. The fragmented approach is the current standard maternity care for most vulnerable women and usually involves women seeing a number of different healthcare professionals throughout pregnancy and postnatally. Few services across the country provide continuity of care throughout pregnancy and childbirth to women with social risk factors[15]. Identifying effective implementation strategies is crucial to develop and scale up continuity of care models that work for vulnerable women in the UK. A culturally competent and community-based model which adopts a life course approach similar to Australian models, might help to close the gap, facilitate care coordination with primary health services and improve the outcomes and experiences of socially disadvantaged populations and women living socially complex lives.

Declaration of interests

All authors declare no competing interests.

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